Missouri Medicaid Psychology/Counseling Billing Book

Created by the Provider Education Unit

PREFACE

This professional training booklet contains information to help you submit claims correctly. The information is only recommended for Missouri Medicaid providers and billers if your Medicaid provider number begins with 49. The booklet is not all-inclusive of program benefits and limitations; providers should refer to specific program manuals for entire content.

Table of Contents

SECTION 1.
MEDICAID PROGRAM RESOURCES
Informational Resources available at www.dss.mo.gov/dms

CONTACTING MEDICAID

PROVIDER COMMUNICATIONS

The following phone numbers are available for Medicaid providers to call the Provider Communications Unit with provider inquiries, concerns or questions regarding proper claim filing, claims resolution and disposition, and recipient eligibility questions and verification. The toll free line provides an interactive voice response system that can answer questions regarding matters including recipient eligibility, last two check amounts, claim status and procedure code status. Providers must use a touchtone phone to access the system.

Provider Communications	800/392-0938
Interactive Voice Response (IVR)	800/392-0938
Standard Line	573/751-2896

The Provider Communications Unit also processes written inquires. Written inquiries should be sent to:

Provider Communications Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

VERIZON INFORMATION TECHNOLOGIES HELP DESK

573/635-3559

Call this number for assistance in establishing the required electronic claims and remittance advice formats, network communication, HIPAA trading partner agreements and assistance with the Verizon Internet billing service.

PROVIDER ENROLLMENT

Providers can contact Provider Enrollment via email as follows for questions regarding enrollment applications: providerenrollment@mail.medicaid.state.mo.us

Changes regarding address, ownership, tax identification number, name (provider or practice), or Medicare numbers must be submitted in writing to:

Provider Enrollment Unit
Division of Medical Services
PO Box 6500
Jefferson City, Missouri 65102

THIRD PARTY LIABILITY
573/751-2005
Call the Third Party Liability Unit to report injuries sustained by Medicaid recipients, problems obtaining a response from an insurance carrier, or unusual situations concerning third party insurance coverage for a Medicaid recipient.

PROVIDER EDUCATION
573/751-6683
Provider Education Unit staff are available to educate providers and other groups on proper billing methods and procedures for Medicaid claims. Contact the Unit for training information and scheduling.

RECIPIENT SERVICES
800/392-2161 or 573/751-6527
The Recipient Services Unit assists recipients regarding access to providers, eligibility, covered and non-covered services and unpaid medical bills.

MEDICAID EXCEPTIONS AND DRUG PRIOR AUTHORIZATION HOTLINE
800/392-8030
Providers can call this toll free number to initiate an emergency request for an essential medical service or an item of equipment that would not normally be covered under the Medicaid program, or to request a drug prior authorization. The Medicaid exceptions fax line for non-emergency requests only is 573/751-2439.

Health Insurance Portability and Accountability Act (HIPAA) Information

Billing providers who want to exchange electronic information transactions with Missouri Medicaid can access the *HIPAA Companion Guide* online by going to the Division of Medical Services web page at www.dss.mo.gov/dms and clicking on the HIPAA Companion Guide link in the Quick Link box at the top of the page.

To access the *X12N Version 4010A1 Companion Guide*: 1) select Missouri Medicaid Electronic Billing Layout Manuals; 2) select System Manuals; 3) select Electronic Claims Layout Manuals; and, 4) select X12N Version 4010A1 Companion Guide.

For information on the Missouri Medicaid Trading Partner Agreement: 1) select Section 1 - Getting Started; and, 2) select Trading Partner Registration.

All questions concerning the Trading Partner Agreement or provider testing schedules are to be directed to the Verizon Help Desk, 573-635-3559.

INTERACTIVE VOICE RESPONSE (IVR)
800/392-0938

The Provider Communications Unit toll-free number, 800/392-0938 is answered by an Interactive Voice Response (IVR) unit which requires a touchtone phone. The nine digit Medicaid provider number **must** be entered each time any of the IVR options are accessed. Callers are limited to ten inquiries per call on any of the options. Providers whose numbers are inactive may utilize the IVR only for dates of service during their active status.

Option 1 Recipient Eligibility

Recipient eligibility **must** be verified **each** time a recipient presents and should be verified **prior** to the service. Eligibility information can be obtained by a recipient's Medicaid number (DCN), social security number and date of birth, or if a newborn, using the mother's Medicaid number and the baby's date of birth. Callers cannot inquire on dates that exceed one year prior to the current date. Callers will be given a confirmation number and this number should be kept as proof of the information received.

Option 2 Last Two Check Amounts

Using this option, the caller will be given the last two Remittance Advice (RA) dates, RA numbers, and check amounts.

Option 3 Claim Status

After entering the recipient's Medicaid number (DCN) and the date of service, the caller will be provided the status of the most current claim in the system containing the date of service entered. The caller will be told whether the claim is paid, denied, approved to pay or is being processed. In addition, the system will give the amount paid, the RA date and the Internal Control Number (ICN).

Option 4 Procedure Code Status **(ELIMINATED)**

Option 5 Medicaid Information Messages

The caller will be given the option to select from several recorded messages providing the latest information about the Medicaid program.

INTERNET SERVICES FOR MEDICAID PROVIDERS

The Division of Medical Services (DMS), in cooperation with Verizon Information Technologies, has an Internet service for Missouri Medicaid providers. Missouri Medicaid providers have the ability to:

- Submit claims and receive claim confirmation files;
- Verify recipient eligibility;
- Obtain remittance advices (RAs);
- Submit Adjustments;
- Submit attachments; and
- View and download public files.

The web site address for this service is **www.emomed.com**. Without proper authorization, providers are unable to access the site. Only providers who are approved to be electronic billers can enroll and utilize the web site services. To participate, the provider must contact the Verizon Information Technologies help desk at (573)635-3559 to obtain an Application for Missouri Medicaid Internet Access Account. A copy of the application is included later in this section. It is available also at the DMS web site, **www.dss.mo.gov/dms**. The application must be completed and returned to:

Verizon Information Technologies
ATTN: EMC Coordinators
P.O. Box 177
Jefferson City, MO 65102-0177

Once the application has been processed and approved, the applicant will receive a certified letter with the information required to begin using the web site. The letter will include a user ID and an initial password. The user can later change the password to one of the user's own choice.

An authorization is required for each individual person within a provider's office who will be accessing the Internet site.

There is no cost for this service except for the cost of an Internet service provider access to the Internet. Additionally, there are no special software requirements, however, the user (provider) must have the proper web browser. The provider must have one of the following web browsers: Internet Explorer 5.0 or higher or Netscape 4.7 or higher. The Internet site is available 24 hours a day, 7 days a week with the exception of being down for scheduled maintenance.

VERIFYING RECIPIENT ELIGIBILITY THROUGH THE INTERNET

Providers can access Missouri Medicaid recipient eligibility files via the web site. Functions include eligibility verification by recipient ID, casehead ID and child's date of

birth, or Social Security number and date of birth. Eligibility verification can be performed on an individual basis or in a batch file. Individual eligibility verification occur in real-time basis similar to the Interactive Voice Response System, which means a response is returned immediately. Batch eligibility verifications are returned to the user within 24 hours.

A batch eligibility confirmation file can either be downloaded for viewing purposes or to be printed.

MEDICAID CLAIMS SUBMISSION THROUGH THE INTERNET

The following claim types, as defined by HIPAA Transaction and Code Set regulations, can be used for Internet claim submissions:

- 837 - Health Care Claim
  - Professional
  - Dental
  - Institutional (hospital inpatient and outpatient, nursing home, and home health care)
- Pharmacy (NCPDP)

The field requirements and filing instructions are similar to those for paper claim submissions. For the provider's convenience, some of the claim input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

A batch claim confirmation file can either be downloaded for viewing purposes or to be printed.

OBTAIN A REMITTANCE ADVICE THROUGH THE INTERNET

Providers have the capability to receive and download a Remittance Advice (RA) from the Internet. The RA format complies with the HIPAA 835, Health Care Claim Payment Advice, regulation. Access to this information is restricted to users with proper authorization. The RA must be downloaded in order to be viewed or printed by the provider. Access to this confidential information is restricted to authorized persons only. Call the Verizon Information Technologies Help Desk at 573/635-3559 for required program formats and the Remittance Advice agreement.

ADJUSTMENTS THROUGH THE INTERNET

Providers have options on the Internet Medical, Dental, Inpatient, Outpatient and Nursing Home claims for a "Frequency Code" that will allow either a 7 – Replacement (Adjustment) or an 8 – Void (credit). This will control an individual adjustment or void, but not group adjustments or voids. Claim adjustments and credits can be submitted by utilizing the CLM, field CLMO5-3, segment of the 837 Health Care Claim.

RECEIVE PUBLIC FILES THROUGH THE INTERNET

Several public files are available for viewing or downloading from the web site including the claims processing schedule for the State fiscal year that begins July 1 and ends June 30. Providers also have access to a listing of the Adjustment Reason Codes and Remittance Advice Remark Codes.

Verizon

Application for
Missouri Medicaid Internet Access Account

Please print or type information and thoroughly complete steps 1 - 4. *Questions? Call 573-635-3559.*
Complete this form for each person requiring an id and password. Id and password may not be shared between users of the Emomed.com application.

1. User Information – Please type or print legibly

Name of Individual User (first, middle, last) _____

Social Security Number _____-_____-_____

Birth Date (mm-dd-yy) _____-_____-_____

Business Street Address (no P.O. Box) _____

Business City & State _____

Business Zip code _____

Business Telephone Number (_____)_____-_____

Internet email address (e.g. userid@company.com) _____

Helpdesk Security Question
(For security reasons, you will be asked for a 'helpdesk security word' when calling for account activities such as password resets. In the event you forget your 'helpdesk security word', the helpdesk person will use this question to jog your memory. Examples include 'What is my mother's maiden name?', 'What is my favorite flavor of ice cream?', etc.) _____

Helpdesk Security Word
(This word is the answer to the question on the left.) _____

2. Authorized Medicaid Provider Names & Numbers (please provide all Medicaid Provider Names & Numbers for which you are authorized to manage electronic claim information.) Attach additional sheet if needed.

Provider Name	Provider number	Provider Name	Provider number

Internet Account Application, page 1 of 2

3. Agreement and Signature

The Undersigned acknowledges, understands and agrees that records and information which are related to the Missouri Medicaid program are confidential and shall be released or revealed only to authorized persons as provided for by law. The Undersigned understands and agrees that state and federal law mandate confidentiality of patient and provider health care information and provide substantial civil and criminal penalties for unauthorized access, use, or disclosure of confidential patient and provider information. The Undersigned on behalf of the business entity and himself or herself acknowledges to keep and maintain confidential all patient and provider information and to only disclose same in the performance of the Undersigned's or the business entity's official duties. In the event the Undersigned or the business entity for whom the Undersigned is employed or acting as agent therefore shall violate state and federal law related to the confidentiality of patient or provider information, the Undersigned and the business entity employing the Undersigned or for whom the Undersigned is an agent thereof shall indemnify, defend and hold Verizon Data Services Incorporated, its parent, affiliates, subsidiaries and contractors harmless from and against any and all claims, demands and actions, (without limiting the generality of the foregoing) which arise out of or relate to any violation of federal and state law, and shall pay all costs including, but not limited to, attorney's fees, judgments, investigative costs and court costs. The Undersigned represents and warrants that he or she has the authority to sign and bind the business entity.

_____

Legal Name of Business Entity

MUST BE SIGNED IN PRESENCE OF NOTARY	SIGNATURE OF APPLICANT ▶	DATE

NOTARY INFORMATION

NOTARY PUBLIC EMBOSSER SEAL	STATE OF	COUNTY
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF 20__	USE RUBBER STAMP IN CLEAR AREA BELOW
	NOTARY PUBLIC SIGNATURE ▶ / MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	

4. Mail Form to (faxes are not allowed):

Verizon
Attn: EMC Coordinators
P.O. Box 177
Jefferson City, MO 65102-0177

NOTE: after your request is approved and processed, you will receive a certified letter in the mail with all information required to begin using your account. Thank you.

Internal Use Only

Approved By **Account Number** **Date processed**

MISSOURI MEDICAID PROVIDER MANUALS ON-LINE
www.dss.mo.gov/dms

How To Download/Print a Provider Manual

The following information assumes you are using a Microsoft Windows based operating system as your operating system. In order to be able to download and use all or a portion of an on-line Medicaid provider manual, you must have Adobe Acrobat Reader. If you already have this on your computer, you may disregard the first section and go directly to the sections detailing how to download and print the manuals.

NOTE: The provider manual information you download is current as of the time it is downloaded. Since periodic updates are made to the manuals, you must do a new download periodically so that your file will have the new or updated information.

A. Accessing and downloading Adobe Acrobat Reader program .

1. Open the DMS home page at **www.dss.mo.gov/dms**.
2. Scroll down, click on and open the line/link titled "Missouri Medicaid Provider Manuals".
3. In the newly opened page, scroll down and click on the yellow and red box at the bottom of the page titled "Get Acrobat Reader".
4. Once you have opened the Adobe Acrobat page, follow the instructions to download the free Adobe Acrobat Reader program to your computer system. Generally, the program will be installed in the C:/programs folder although you can put it in any folder you want. Download time is approximately 20-30 minutes depending on the speed of your modem and Internet service provider.

B. Downloading and saving all or portions of a provider manual.

1. Go to the DMS home page at **www.dss.mo.gov/dms**.
2. Scroll down, click on and open the line/link titled "Missouri Medicaid Provider Manuals".
3. A new page will open. Click on the link titled “Missouri Medicaid Provider Manuals”.
4. On the left side of the newly opened page, click on the “+” in front of the folder titled “Print A Manual” and click again on the subfolder. This opens a new frame in the upper right area of the screen titled “Print a Manual”. In this frame scroll down to the provider manual you want to access and click on the manual to open to its contents page. Disregard the frame in the lower area of the page titled “Search Results”.
5. When the page opens, it will display a number of links from which you can choose the one you want. The links allow you to access either the complete manual or sections of the selected manual.

For Internet Explorer Browser Users

For example, if you wish to download the entire physician's manual, place your pointer on the line/link titled "Complete Manual" and right click. A pop-up

menu will appear. Click on the "Save Target As" button. Another pop window (Save As) will appear. Select where you want to save the file and its name. It can be saved either to a floppy disk or to a folder on the hard drive. If you rename the file, be sure to put the .pdf extension at the end of the new name. Click on the save button. The material then will be saved to the location/name you specified. Actual download time will vary depending on the file size of the information you want to download and the speed of your system's modem and your Internet service provider's system. Downloading a complete manual can take 5-10 minutes.

For Netscape Browser Users

For example, if you wish to download the entire physician's manual, place your pointer on the line/link titled "Complete Manual" and right click. A pop-up screen will appear. Click on "Save Link As". In the next pop-up window, select the drive/ folder where you want to save the date. You may rename file if you wish a name other than the name presented by the system. Add or change the file extension to .pdf (at the end of the file name), e.g. change phyman to phyman.pdf. Click save and the data will be saved to the location/name you specified. Actual download time will vary depending on the file size of the information you want to download and the speed of your system's modem and your Internet service provider's system. Downloading a complete manual can take 5-10 minutes.

6. Close the screens all the way back to the browser. Close the browser screen and return to your desktop.

C. Using Adobe Acrobat Reader to access the saved manual file.

1. Open Acrobat Reader either using the desktop icon or the program file.
2. Once the work screen is open, click on "File" in the taskbar.
3. On the task screen, select and click on "Open".
4. Select and highlight the drive location and name of your file. Acrobat Reader then will open your file.
5. You now have the option of viewing or printing all or portions of the file.

D. Printing all or portions of an opened Acrobat Reader Document

1. Click on "File" on the taskbar.
2. On the task screen, select and click on "Print" or "Print Target".
3. You have three options for printing from the file. All - prints the entire file Current Page - prints only the page you have selected/highlighted. Pages - gives you the option to print a specified range of consecutive pages.
4. When the print command has been sent to the printer, select "File" on the taskbar and "Exit" in the task screen to exit the program and return to your desktop.

CLAIM AND ATTACHMENT MAILING ADDRESSES

Medicaid paper claims and attachments related to claims must be sent to the following address as indicated.

Verizon Information Technologies, Inc.
P.O. Box (see below for correct PO box number)
Jefferson City, MO 65102

P.O. Box 5100……. Inpatient Hospital Claims
P.O. Box 5200……. Outpatient Hospital Claims and RHC Claims
P.O. Box 5300……. Dental Claims
P.O. Box 5400……. Pharmacy Form Paper Claims
P.O. Box 5500……. Nursing Home Paper Claims
P.O. Box 5600……. DME, HCFA-1500, and Home Health Agency Claims
P.O. Box 5700……. Prior Authorization Requests
P.O. Box 5900……. Attachments forms including Second Surgical Opinion, Acknowledgment of Receipt of Hysterectomy Information, SURS Referral, Oxygen & Respiratory Equipment Medical Justification and Certificate of Medical Necessity (DME providers only)

Verizon's physical address is: Verizon Information Technologies
905 Weathered Rock Road
Jefferson City, MO 65101

CLAIMS PROCESSING SCHEDULE FOR STATE FISCAL YEAR 2004

Cycle Run/Remittance Date* -	Check Date -
Friday, June 20, 2003	Monday, July 7, 2003
Friday, July 11, 2003	Monday, July 21, 2003
Friday, July 25, 2003	Tuesday, August 5, 2003
Friday, August 8, 2003	Wednesday, August 20, 2003
Friday, August 22, 2003	Friday, September 5, 2003
Friday, September 5, 2003	Monday, September 22, 2003
Friday, September 19, 2003	Monday, October 6, 2003
Friday, October 10, 2003	Monday, October 20, 2003
Friday, October 24, 2003	Wednesday, November 5, 2003
Friday, November 7, 2003	Thursday, November 20, 2003
Friday, November 21, 2003	Friday, December 5, 2003
Friday, December 5, 2003	Monday, December 22, 2003
Friday, December 19, 2003	Monday, January 5, 2004
Friday, January 9, 2004	Tuesday, January 20, 2004
Friday, January 23, 2004	Thursday, February 5, 2004
Friday, February 6, 2004	Friday, February 20, 2004
Friday, February 20, 2004	Friday, March 5, 2004
Friday, March 5, 2004	Monday, March 22, 2004
Friday, March 19, 2004	Monday, April 5, 2004
Friday, April 9, 2004	Tuesday, April 20, 2004
Friday, April 23, 2004	Wednesday, May 5, 2004
Friday, May 7, 2004	Thursday, May 20, 2004
Friday, May 21, 2004	Monday, June 7, 2004
Friday, June 4, 2004	Monday, June 21, 2004

*The Cycle Run Dates are tentative dates calculated by the Division of Medical Services. The dates are subject to change without prior notification.

*All claims submitted electronically to Verizion, must be received by 5:00 p.m. of the Cycle Run/Remittance Advice date in order to pay on the corresponding check date.

State Holidays for State Fiscal Year 2004

July 4, 2003 Independence Day	January 1, 2004 New Years Day
September 1, 2003 Labor Day	January 19, 2004 Martin Luther King Day
October 13, 2003 Columbus Day	February 12, 2004 Lincoln's Birthday
November 11, 2003 Veteran's Day	February 16, 2004 Washington's Birthday
November 27, 2003 Thanksgiving	May 10, 2004 Truman's Birthday
December 25, 2003 Christmas	May 31, 2004 Memorial Day

SECTION 2.
CMS-1500 CLAIM FILING INSTRUCTIONS

The CMS-1500 claim form should be legibly printed by hand or electronically. It may be duplicated if the copy is legible. Medicaid paper claims should be mailed to:

Verizon Information Technologies
P.O. Box 5600
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at **www.dss.mo.gov/dms**.

NOTE: An asterisk (*) beside field numbers indicates required fields. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicates a field is required in specific situations.

Field number and name		Instructions for completion
1.*	Type of Health Insurance Coverage	Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For example, if a Medicare claim is being filed, check the Medicare box, if a Medicaid claim is being filed, check the Medicaid box and if the patient has both Medicare and Medicaid, check both boxes.
1a.*	Insured's I.D.	Enter the patient's eight-digit Medicaid or MC+ ID number (DCN) as shown on the patient's ID card.
2.*	Patient's Name	Enter last name, first name, middle initial *in this order* as it appears on the ID card.
3.	Patient's Birth Date Sex	Enter month, day, and year of birth. Mark appropriate box.
4.**	Insured's Name	If there is individual or group insurance besides Medicaid, enter the name of the primary policyholder. If this field is completed, also complete fields 6, 7, 11, and 13. If no private insurance is involved, leave blank.
5.	Patient's Address	Enter address and telephone number if available.

6.**	Patient's Relationship to Insured	Mark appropriate box if there is other insurance. If no private insurance is involved, leave blank.
7.**	Insured's Address	Enter the primary policyholder's address; enter policy-holder's telephone number, if available. If no private insurance is involved, leave blank.
8.	Patient Status	Not required.
9.**	Other Insured's Name	If there is other insurance coverage in addition to the primary policy, enter the secondary policyholder's name. If no private insurance is involved, leave blank. (See Note)(1)
9a.**	Other Insured's Policy or Group Number	Enter the secondary policyholder's Insurance policy number or group number, if the insurance is through a group such as an employer, union, etc. If no private insurance is involved, leave blank. (See Note)(1)
9b.**	Other Insured's Date of Birth	Enter the secondary policyholder's date of birth and mark the appropriate box reflecting the sex of the secondary policyholder. If no private insurance is involved, leave blank. (See Note)(1)
9c.**	Employer's Name	Enter the secondary policyholder's employer name. If no private insurance is involved, leave blank. (See Note)(1)
9d.**	Insurance Plan	Enter the secondary policyholder's insurance plan name. If no private insurance is involved, leave blank. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* (See Note)(1)
10a.-10c.**	Is Condition Related to:	If services on the claim are related to patient's employment, an auto accident or other accident, mark the appropriate box. *If the*

		services are not related to an accident, leave blank. (See Note)(1)
10d.	Reserved for Local Use	May be used for comments/descriptions.
11.**	Insured's Policy or Group Number	Enter the primary policyholder's insurance policy number or group number, if the insurance is through a group, such as an employer, union, etc. If no private insurance is involved, leave blank. (See Note)(1)
11a.**	Insured's Date of Birth	Enter primary policyholder's date of birth and mark the appropriate box reflecting the sex of the primary policyholder. If no private insurance is involved, leave blank. (See Note)(1)
11b.**	Employer's Name	Enter the primary policyholder's employer name. If no private insurance is involved, leave blank. (See Note)(1)
11c.**	Insurance Plan Name	Enter the primary policyholder's insurance plan name. *If the insurance plan denied payment for the service provided, attach a valid denial from the insurance plan.* (See Note)(1)
11d.**	Other Health Plan	Indicate whether the patient has a secondary health insurance plan. If so, complete fields 9-9d with the secondary insurance information. (See Note)(1)
12.	Patient's Signature	Leave blank.
13.	Insured's Signature	This field should be completed only when the patient has another health insurance policy. Obtain the policyholder's or authorized person's signature for assignment of benefits. The signature is necessary to ensure the insurance plan pays any benefits directly to the provider of Medicaid. Payment may otherwise be issued to the policyholder requiring the provider to collect insurance benefits from the policyholder.

14.	Date of Current Illness, Injury or Pregnancy	Leave blank
15.	Date Same/Similar Illness	Leave blank.
16.	Dates Patient Unable to Work	Leave blank.
17.	Name of Referring Physician or Other Source	Leave blank
17a	I.D. Number of Referring Physician	Leave blank
18.**	Hospitalization Dates	If the services on the claim were provided in an in-patient hospital setting, enter the admit and discharge dates. If the patient is still in the hospital at the time of filing, write “still” in the discharge date field or show the last date of in-patient service that is being billed in field 24a. This field is required when the service is performed on an in-patient basis.
19.	Reserved for Local Use	Providers may use this field for additional remarks/descriptions.
20.	Lab Work Performed Outside Office	Leave blank
21.*	Diagnosis	Enter the complete ICD-9-CM diagnosis code(s). Enter the primary diagnosis as No. 1, the secondary diagnosis as No. 2, etc.
22.**	Medicaid Resubmission	For timely filing purposes, if this is a resubmitted claim, enter the Internal Control Number (ICN) of the previous related claim or attach a copy of the original Remittance Advice indicating the claim was initially submitted timely.
23.	Prior Authorization Number	Leave blank**.**
24a.*	Date of Service	Enter the date of service under “from” in month/day/year format, using a six-digit format. All line items **must** have a from date.

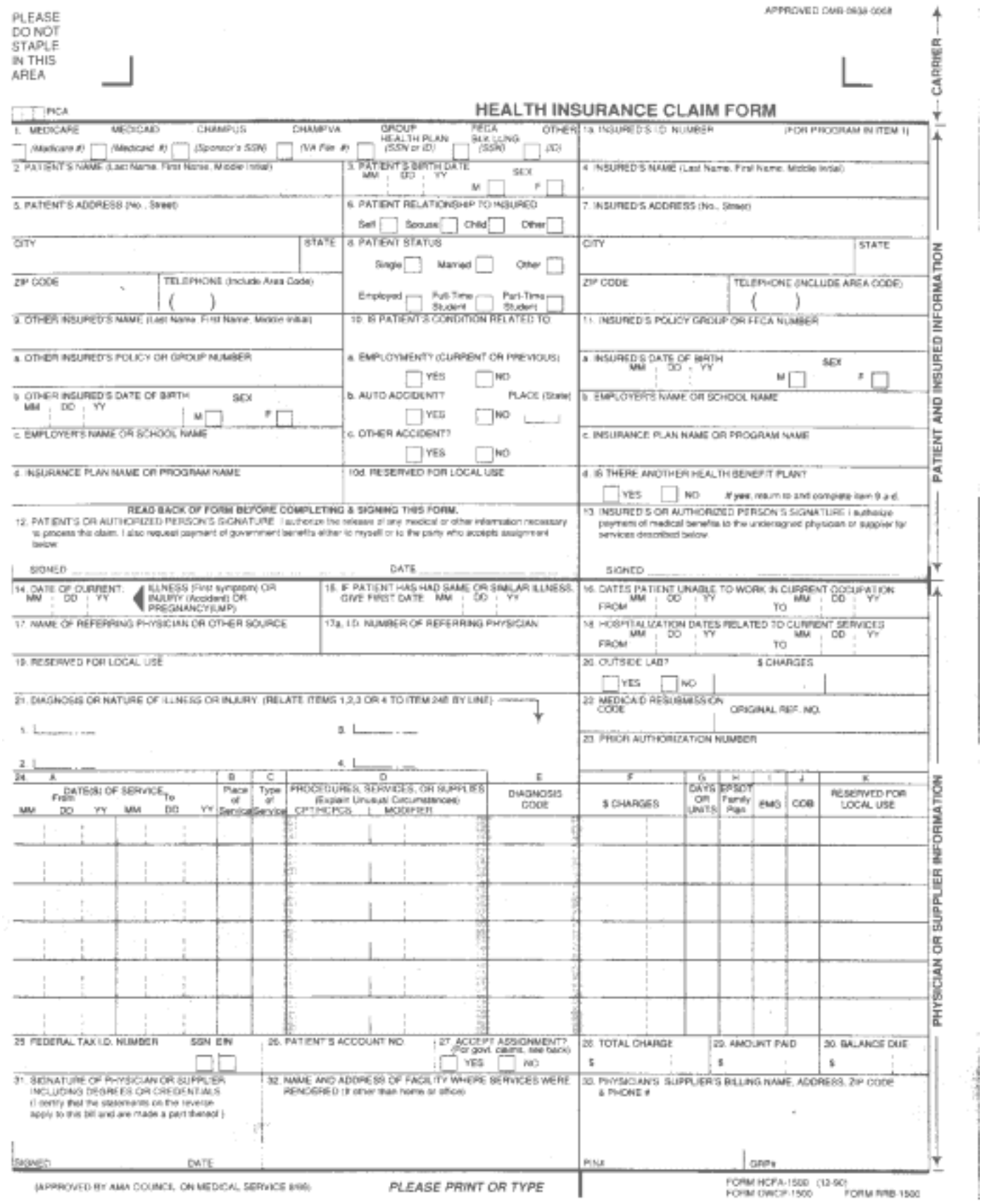
		A “to” date of service is required when billing on a single line for subsequent physician hospital visits on consecutive days.
24b.*	Place of Service	Enter the appropriate place of service code. See Section 15.10 of the Medicaid *Psychology/Counseling Provider Manual* for the list of appropriate place of service codes.
24c.	Type of Service	Leave blank.
24d.*	Procedure Code	Enter the appropriate CPT or HCPCS code and applicable modifier(s), if any, corresponding to the service rendered. (field 19 may be used for remarks or descriptions.)
24e.*	Diagnosis Code	Enter 1, 2, 3, 4 or the actual diagnosis code(s) from field 21.
24f.*	Charges	Enter the provider’s usual and customary charge for each line item. This should be the total charge if days or units are shown.
24g.*	Days or Units	Enter the number of days or units of service provided for each detail line. The system automatically plugs a “1” if the field is left blank.
24h.**	EPSDT/Family Planning	If the service is an EPSDT/HCY screening service or referral, enter “E.” If the service is family planning related, enter “FP.” If the service is both an EPSDT/HCY and Family Planning service enter “B.”
24i.	Emergency	Leave blank.
24j.	COB	Leave blank.
24k.	Performing Provider Number	Leave blank.
25.	SS#/Fed. Tax ID	Leave blank.
26.	Patient Account Number	For the provider’s own information, a maximum of 12 alpha and/or numeric characters may be entered here.
27.	Assignment	Not required on Medicaid claims.

28.*	Total Charge	Enter the sum of the line item charges.
29.**	Amount Paid	Enter the total amount received by all other insurance resources. **Previous Medicaid payments, Medicare payments, cost sharing and co-pay amounts are not to be entered in this field.**
30.	Balance Due	Enter the difference between the total charge (field 28) and the insurance amount paid (field 29).
31.	Provider Signature	Not required.
32.**	Name and Address of Facility	If the services were rendered in a facility other than the home or office, enter the name and location of the facility. This field is required when the place of service is other than home or office.
33.*	Provider Name/ Number /Address	Affix the provider label or write or type the information **exactly** as it appears on the label.

* These fields are mandatory on all CMS-1500 claim form.

** These fields are mandatory only in specific situations, as described.

(1) NOTE: This field is for private insurance information only. If no private insurance is involved **leave blank**. If Medicare, Medicaid, employers name or other information appears in this field, the claim will deny. See Section 5 of the Medicaid *Provider's Manual* for further TPL (Third Party Liability) information.



PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

SECTION 3.
THE REMITTANCE ADVICE (RA)

The Remittance Advice shows claim payment or denial. If the claim has been denied or some other action taken affecting the payment, the RA lists an "Adjustment Reason Code" to explain the denial or other action. The Adjustment Reason Code is from a national administrative code set that identifies the reasons for any differences, or adjustments, between the original provider charge for a claim or service and the payor's reimbursement for it. The RA may also list a "Remittance Remark Code" which is from a national administrative code set for providing either a claim-level or service-level message that cannot be expressed with a claim Adjustment Reason Code.

If a claim is denied, a new or corrected claim form **must** be submitted as corrections **cannot** be made by submitting changes on the RA pages.

Remittance advices for professional services are grouped in the following order.

Crossover Part-B - reimbursement greater than zero
Medical - reimbursement greater than zero
Crossover Part-B - reimbursement equals zero
Medical - reimbursement equals zero
Drug
Adjustments
Credits

Claims in each category are listed alphabetically by the patient's last name.

FIELD NUMBER & NAME		EXPLANATION OF FIELD
1.	Provider Number	The provider's 9-digit Missouri Medicaid number.
2.	Remittance Advice Date	The financial cycle date.
3.	Remittance Advice Number	The Remittance Advice number.
4.	Page	The Remittance Advice page number.
5.	Medical (Claim Type)	The type of claims(s) processed.
6.	Recipient Name	The patient's last name and first name. NOTE: If the patient's name and identification number are *not* on file, only the first two letters of the last name and first letter of the first name appear.

FIELD NUMBER & NAME		EXPLANATION OF FIELD
7.	Medicaid I.D.	The patient's 8-digit Medicaid identification number.
8.	Internal Control Number (ICN)	The 13-digit number assigned to the claim for identification purposes. The first two digits of an ICN indicate the type of claim: 11--Paper Drug 15--Paper Medical 18--Paper Medicare/Medicaid Part B Crossover Claim 40--Magnetic Tape Billing (MTB) includes claims sent by Medicare intermediaries. 41--Direct Electronic Medicaid Information (DEMI) 43--MTB/DEMI 44--Direct Electronic File Transfer (DEFT) 45--Accelerated Submission and Processing (ASAP) 46--Adjudicated Point of Service (POS) 47--Captured Point of Service (POS) 49--Internet 50--Individual Adjustment Request 55--Mass Adjustment 70--Individual Credit to an Adjustment 75--Credit Mass Adjustment The third and fourth digits indicate the year the claim was received. The fifth, sixth, and seventh digits indicate the Julian date. In a Julian system, the days of a year are numbered consecutively from "001" (January 1) to "365" (December 31) ("366" in a leap year). The last digits of an ICN are for internal processing. The ICN number 1503277316020 is read as a paper medical claim entered in the processing system on October 4, 2003. For a drug claim, the last digit of the ICN indicates the line number from the Pharmacy Claim form.
9.	Service Dates	The initial date of service in MMDDYY format followed by the final date of service in MMDDYY format.

FIELD NUMBER & NAME		EXPLANATION OF FIELD
10.	Place of Service (POS)	The 2-digit place of service.
11.	Proc. Code - Mod	The CPT or HCPCS procedure code, including any modifier(s) billed by the provider.
12.	Qty.	The units of service billed.
13.	Billed Amount (Charges)	The amount billed by the provider for the procedure.
14.	Allowed Amount (Charges)	The Medicaid maximum allowed amount for the procedure.
15.	Cut/Back	The difference between the billed amount and the allowed amount.
16.	Payment Amount	The amount Medicaid paid on the claim.
17.	Adjustment Reason Codes	Identifies the reasons for any differences, or adjustments, between the original provider billed amount for a claim or service and Medicaid's payment for it.
18.	Patient Acct	The provider's own patient account name or number.
19.	Remark Codes	Provides either claim level or service level messages that cannot be expressed with an Adjustment Reason Code.
20.	Corrected Priority Pay Name	The state is showing that there is other insurance available for the patient. When a claim denies for other insurance, the name of the commercial carrier is shown. Up to two policies can be shown.
21.	Other Claims Related to ID	The patient's group policy insurance number.
22.	Other Claims Related to ID	The patient's individual insurance policy number.

FIELD NUMBER & NAME	EXPLANATION OF FIELD
23.Category Totals	Each category (i.e., paid crossover, paid medical, denied crossover, denied medical, drug, adjustments) has separate totals for number of claims, billed amount and allowed amount. This field also includes totals for quantity, cutback and other payments, if applicable.
24. Provider Totals	Totals for this provider for this RA.
25. Spenddown Amount	Total spenddown amount(s) for this provider for this RA.
26. Earnings Data	Shows fiscal year-to-date total of claims processed and reimbursements paid to the provider.

PROVIDER NUMBER: 200000000 (1) STATE OF MISSOURI MEDICAID RA # 09999999 (3)
MEDICAL (5) REMITTANCE ADVICE AS OF 10-10-03 (2) PAGE 2 (4)

RECIPIENT NAME (6)	MEDICAID I.D. (7)	INTERNAL CONTROL NUMBER (8)	SERVICE DATES FROM MMDDYY (9)	TO MMDDYY	P O S (10)	PROC CODE-MOD (11)	QTY (12)	BILLED AMOUNT (13)	ALLOWED AMOUNT (14)	CUT/ BACK (15)	PAYMENT AMOUNT (16)	ADJUST REASON CODES (17)
KROSS,IMA	09004999	1503279009999	092903	092903	11	99213	1	42.44	24.00	18.44-	24.00	A2
		PAT ACCT: KR025										
(18)			092903	092903	11	85024	1	35.00	11.70	23.30-	11.70	A2
			092903	092903	11	82948	1	18.00	1.00	17.00-	1.00	A2
			092903	092903	11	83036	1	40.00	13.41	26.59-	13.41	A2
			092903	092903	11	80061	1	50.00	18.51	31.49-	18.51	A2
				****CLAIM TOTALS :			5		68.62		68.62	
								185.44		116.82-		
*** REMARK CODES: N59												
(19)												
JONES,MARY	05513849	4403280009898	100103	100103	11	99213	1	45.00	24.00	21.00-	24.00	A2
		PAT ACCT: JO398										
(18)			100103	100103	11	82948	1	18.00	1.00	17.00-	1.00	A2
			100103	100103	11	36415	1	4.00	.00	4.00-	.00	125
				****CLAIM TOTALS :			3		25.00		25.00	
								67.00		42.00-		
*** REMARK CODES: N59 MA66												
(19)												
SMITH,JOHN	29030841	1503279006789	100103	100103	11	99213	1	42.44	24.00	18.44-	24.00	A2
		PAT ACCT: SM145										
			100103	100103	11	81003	1	12.00	.00	12.00-	.00	125
				****CLAIM TOTALS :			2		24.00		24.00	
								54.44		30.44-		
*** REMARK CODES: MA66												
(19)												
SMITH, WILL	77889911	1503279000987	100103	100103	11	99213	1	42.00	.00	42.00-	.00	22
***REMARK CODES: MA92												
(19)												

CORRECTED PRIORITY PAYER NAME: (20) DMS HEALTHCARE
OTHER CLAIMS RELATED ID: (21) AA345678
OTHER CLAIMS RELATED ID: (22) 555495755

****CATEGORY TOTALS : (23)	NUMBER OF CLAIMS =	4	11	117.62		117.62
			348.88		231.26-	
****PROVIDER TOTALS : (24)	NUMBER OF CLAIMS =	4	11	117.62		117.62
			348.88		231.26-	
	SPENDDOWN AMOUNT: (25)	.00				

** EARNINGS DATA *** (26)	CURRENT
NO. OF CLAIMS PROCESSED	75
DOLLAR AMOUNT PROCESSED	1,752.71
CHECK AMOUNT	1,752.71

SECTION 4
CODES AND LIMITATIONS

ALL CHILDREN

✏ Assessment – Insight (90801)
- no PA is required
- maximum of 6, 30-minute units per rolling year
- allowed per provider

✏ Assessment – Interactive (90802)
- no PA is required
- maximum of 2, 30-minute units per rolling year, submit with progress notes
- allowed per provider

✏ Testing (96100)
- no PA required
- maximum of 4 hour units per rolling year

✏ Crisis Intervention (S9484)
- no PA required
- maximum of 6 hour units per rolling year
- additional units beyond 6 require prepayment review, submit with progress notes
- children 0 through 2 year of age require attachment of progress notes with claim

AGES 0-20

✏ Individual Therapy (90804/90806)
-maximum of 1 procedure per day, additional units not allowed
-5 procedures per month
-additional units beyond 5 per month require prepayment review

✏ Family Therapy (90846/90847)
-maximum of 2 units per procedure per day, additional units not allowed
-10 units per month
-additional units beyond 10 per month require prepayment review

✏ Group Therapy (90853)
-maximum of 3 units per day, additional units not allowed
-15 units per month
-additional units beyond 15 per month require prepayment review

NO CHANGE IN POLICY FOR LCSW and LPC:

✏ Family Therapy Without the Patient Present (90846)
-PA required for all children 0 through 20

✏ Children Age: 0 through 2 (90804/90806/90847/90853)
-PA continues to be required for individual therapy, family therapy with the patient present and group therapy

Note: Services provided while the patient is hospitalized will not require PA nor count toward above monthly/yearly limits.

NEW POLICY FOR PSYCHOLOGIST ONLY:

- Family Therapy without patient present (90846)
  - PA no longer required
  - Certificate of Medical Necessity (CMN) or progress notes must be included with claim for all children 0-20

- Children age: 0-2 (90804,90806,90847,90853)
  - PA no longer required
  - CMN or progress notes must be included with claim for individual, family with patient present and group therapy.

The use of a CMN does not negate the need for progress notes being included in the client's file.

PRIOR AUTHORIZATION

- Services which require prior authorization are:
  Family therapy without the patient present when done by LCSW or LPC
  ALL therapy services for children under the age of three when done by LCSW or LPC.

- Prior authorization must be requested and approved prior to the start of service. A disposition letter will be sent to the provider with a status indicator of:
  A - approved
  I - incomplete
  D - denied
  If the disposition letter status is an I or D, the PA request must be corrected and resubmitted with the appropriate documentation.

- An initial prior authorization request must be accompanied by a treatment plan outlining the frequency, duration, and scope of the services requested, short term goals, long term goals, and a discharge plan. Services can be prior authorized for up to 180 days.

  A prior authorization request for subsequent service must include an updated treatment plan as described above and progress notes of at least the last three (3) visits.

- All prior authorizations are sent directly to Verizon Information Technologies, P.O. Box 5700, Jefferson City, MO 65102 with the exception of services furnished by an employee of Department of Mental Health (DMH) Authorized Agent. Those providers should follow the instructions furnished by DMH.

- The Family Support Division (FSD) (formerly Division of Family Services), does not authorize services but may make referrals. Providers are expected to comply with policies and procedures established by FSD for the documentation and reports required for individuals in their care and custody. Referrals made by FSD does not negate the need for prior authorization according to Division of Medical Services (DMS) policy.

INDIVIDUAL TREATMENT PLAN

RECIPIENT NAME: _____

RECIPIENT MEDICAID NUMBER (DCN): _____

ICD-9CM DIAGNOSIS CODE AND DESCRIPTION

PRIMARY: _____

SECONDARY: _____

PROGNOSIS: _____

PRESENTING PROBLEM DESCRIPTION AND PSYCHOSOCIAL INFORMATION:

_____

_____

_____

_____

FREQUENCY:

_____

_____

_____

DURATION:

_____

_____

_____

TREATMENT PLAN CONTINUED FOR: _____

RECIPIENT MEDICAID NUMBER (DCN): _____

SCOPE:

_____

_____

_____

SHORT TERM GOALS:

_____

_____

_____

LONG TERM GOALS:

_____

_____

_____

DISCHARGE PLAN:

_____

_____

_____

_____

NOTE: ATTACH ADDITIONAL SHEETS AS REQUIRED. INDICATE NAME AND DCN ON EACH PAGE.

DOCUMENTATION REQUIREMENTS

Reimbursement for each date of service requires all of the following documentation in the patient's medical record:

- The specific services rendered;
- The date and actual time taken to deliver the services; (e.g. 4-4:30 p.m.)
- The setting in which service was rendered;
- The pertinence of the service to the Treatment Plan;
- Identification of other agencies working with the client;
- Plans for coordinating services with other agencies;
- Identify medications which have been prescribed for the individual;
- Client's progress toward the goals stated in the Treatment Plan (progress notes).

These requirements do not replace or negate documentation/reports required by the FSD for individuals in their care or custody. Providers are expected to comply with policies and procedures established by FSD.

TIME-BASED SERVICE LIMITATIONS

A procedure code representing a measure of time is covered for one (1) unit per day. The provider must choose the appropriate time measure to represent the service furnished.

A unit of service which represents 20-30 minutes must include at least 20 minutes face-to-face with the client. When less that 30 minutes is spent face-to-face with the client, the remainder of the time must be directed towards the benefit of the client, including, but not limited to, report writing, note summary, reviewing treatment plan, etc.

A unit of service which represents 45-50 minutes must include at least 45 minutes face-to-face with the client. When less than 50 minutes is spent face-to-face with the client, the remainder of the time must be directed towards the benefit of the client, including, but not limited to, report writing, note summary, reviewing treatment plan, etc.

Providers may not bill a combination of any psychotherapy codes that have the same description, except for time, on the same date of service. For example a half hour of 90804 and 45-50 minutes of 90806 is not covered on the same date of service.

Providers may not bill a combination of time measured psychotherapy codes with a code including a medical component. For example 90804 and 90805 are not covered on the same date of service.

Certain services include a medical component and are not billable by a psychologist, LCSW, or LPC. These codes are: 90805, 90807, 90811, 90813, 90817, 90819, 90824, 90827, 90862, 90865, 90870 and 90871.

Certain services are not covered when provided by a LCSW or LPC and may not be billed for an adult or child when furnished by an LCSW or LPC in any setting. These codes are 90899, 90880, 96100, 96105, 96111, 96115.

FAMILY THERAPY (90846/90847)

Family therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When family therapy without the patient present (90846) or family therapy with the patient present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session. If family therapy is directed at more than one member of the family, the provider is limited to one unit per day, and may focus on different members of the family as needed during the session. Treatment of family members (adults) is not covered when provided by an LCSW or LPC. Family therapy furnished by an LCSW or LPC, must be directed exclusively to the treatment of the child. Parental issues may not be billed.

A psychologist may bill for services provided to an adult. When a family consists of a Medicaid/MC+ eligible adult and child(ren) and the therapy is not directed at one specific child, services may be directed to the adult for effective treatment of the family unit to address the adult's issues and impact on the family. If the adult is not eligible and the family therapy is directed to the adult and not the child, the service may not be billed using the child's DCN.

If there is more than one eligible child and no child is exclusively identified as the primary recipient of treatment, then the oldest child's DCN must be used for billing purposes.

A family may be biological, foster, adoptive or other family unit. A family is not a group and **providers may not submit a claim for each eligible person attending the same family therapy session.**

GROUP THERAPY (90853)

Group therapy must consist of a group oriented process delivered to 3 but no more than 8 individuals who are not members of a family. Currently the CPT definition is not time limited and DMS defines a unit of service as a half-hour. A maximum of 3 units per day is covered. Additional units per day are not allowed. A maximum of 15 units per month is allowed; however, additional units beyond the 15 per month may be covered but require prepayment review.

Group therapy may not be billed on the same date of service as family therapy (90846 or 90847) unless the recipient is inpatient, in a residential treatment facility or custodial care facility. Group therapy in a group home is billed with POS-14. Group therapy in a residential/custodial facility is billed with POS-33. Group therapy in a shelter type setting is billed with POS-99.

DIAGNOSIS CODES

The diagnosis code must be a valid ICD-9 diagnosis code and must be mental health related. This does not include mental retardation. The only valid codes for the psychology/counseling program are 290-316, V11-V118, V154-1542, V17-170, V40-V401, V61-V619, V624, V628-V6289, V673, V710- V7102, and V79-V791.

The diagnosis code V20.2 is the only valid diagnosis code for a partial Healthy Children and Youth (HCY) screening.

SCHOOL BASED SERVICES

When services are provided on public school grounds, the provider must enroll with a pay-to of the school district in which the school is located. A Missouri Medicaid provider number is required for each school district where services are being provided. The only appropriate place of service for a public school setting is 03 and must be used. Services provided in a private school setting must be billed with POS-99.

MODIFIERS

Effective for dates of service November 01, 2003 and after claims must be submitted using the appropriate modifier(s). The specialty modifier is always required.

AH - psychologist	AJ - licensed clinical social worker
UD - licensed professional counselor	U8 - in home (12) or other (99)

PROCEDURE CODES FOR LCSW AND LPC

The procedure codes listed below are the only counseling codes billable by an LCSW or LPC. The appropriate AJ or UD must be used for all codes.

Procedure Code	Modifier	Maximum Allowed	Maximum Quantity	Description
90801		$24.00	6	Assessment
90801	U8	$29.00	6	Assessment-home/other
90802		$24.00	2	Assessment-interactive(intac)
90802	U8	$29.00	2	Assessment-interactive-home/other
90804		$24.00	1	Individual 20-30 mins
90804	U8	$29.00	1	Individual 20-30 mins- home/other
90806		$48.00	1	Individual 45-50 mins
90806	U8	$58.00	1	Individual 45-50 mins- home/other
90810		$24.00	1	Intac Indiv 20-30 mins
90810	U8	$29.00	1	Intac Indiv 20-30 mins- home/other
90812		$48.00	1	Intac Indiv 45-50 mins
90812	U8	$58.00	1	Intac Indiv 45-50 mins-home/other
90816		$24.00	1	Indiv hosp 20-30 mins
90818		$48.00	1	Indiv hosp 45-50 mins
90823		$24.00	1	Intac Indiv Hosp 20-30 mins
90826		$48.00	1	Intac Indiv Hosp 45-50 mins
90846		$24.00	2	Family w/o Patient
90846	U8	$29.00	2	Family w/o Patient-home/other
90847		$24.00	2	Family w/ Patient
90847	U8	$29.00	2	Family w/ Patient-home/other
90853		$10.00	3	Group Therapy
S9484		$48.00	6	Crisis Intervention, hour
S9484	U8	$53.00	6	Crisis Intervention, hour-home/other

PROCEDURE CODES FOR PSYCHOLOGISTS

The procedure codes listed below are the only counseling codes billable by a psychologist. The AH modifier must be used on all codes.

Procedure Code	Modifier	Maximum Allowed	Maximum Quantity	Description
90801		$30.00	6	Assessment
90801	U8	$35.00	6	Assessment-home/other
90802		$30.00	2	Assessment-interactive(intac)
90802	U8	$35.00	2	Assessment-interactive-home/other
90804		$30.00	1	Individual 20-30 mins
90804	U8	$35.00	1	Individual 20-30 mins- home/other
90806		$60.00	1	Individual 45-50 mins
90806	U8	$70.00	1	Individual 45-50 mins- home/other
90810		$30.00	1	Intac Indiv 20-30 mins
90810	U8	$35.00	1	Intac Indiv 20-30 mins- home/other
90812		$60.00	1	Intac Indiv 45-50 mins
90812	U8	$70.00	1	Intac Indiv 45-50 mins-home/other
90816		$30.00	1	Indiv hosp 20-30 mins
90818		$60.00	1	Indiv hosp 45-50 mins
90823		$30.00	1	Intac Indiv Hosp 20-30 mins
90826		$60.00	1	Intac Indiv Hosp 45-50 mins
90846		$30.00	2	Family w/o Patient
90846	U8	$35.00	2	Family w/o Patient-home/other
90847		$30.00	2	Family w/ Patient
90847	U8	$35.00	2	Family w/ Patient-home/other
90853		$12.50	3	Group Therapy
90880		$8.00	1	Hypnotherapy
90885		$24.00	1	Psych eval of records
90899		Man Price	1	Unlisted Psych code
96100		$60.00	4	Testing
96100	U8	$60.00	4	Testing- home/other
96105		$35.00	1	Assess of aphasia
96111		$35.00	1	Developmental testing, extended
96115		$35.00	1	Neurobehavior status exam
S9484		$60.00	6	Crisis Intervention, hour
S9484	U8	$65.00	6	Crisis Intervention, hour- home/other

HCY SCREENINGS

Effective with date of service October 16, 2003, the HCY screening code W0025 is no longer a valid code. Developmental/Mental Health Partial Screens are billable by a psychologist, LCSW or LPC with the new codes. These screening codes do not use the AH, AJ, or UD modifiers, instead the codes must have a 59 modifier and if the child is referred on for further care, a UC modifier. The diagnosis code V20.2 is the only valid diagnosis code for a partial Healthy Children and Youth (HCY) screening.

Proc. Code for Svc. Dates prior to 10-16-03	Modifier	Proc. Code for Svc. Dates after 10-16-03	New Modifier 1	New Modifier 2	Fee
W0025	XE	99429	59		$15.00
W0025	XF	99429	59	UC	$15.00

Modifier "UC" must be used if child was referred for further care as a result of the screening. Modifier "UC" must always appear as the last modifier.

ADJUSTMENT REQUESTS

REFER TO SECTION 6 FOR ADDITIONAL INFORMATION REGARDING SUBMISSION OF ADJUSTMENTS

- Utilize the adjustment request form when a claim pays incorrectly (e.g., one unit paid and two units should be paid.
- Only paid claims can be adjusted. Unpaid claims must be corrected and resubmitted.
- Adjustments must be filed within eighteen months of the remittance advice where the claim paid.
- Adjustments cannot be processed if the difference in the payment is less than four dollars.
- Attach a copy of the remittance advice and claim to the adjustment request.

Adjustment transactions will appear on the remittance advice so there will be data history. **DO NOT** attempt to send a check for an overpayment.

SECTION 5
PRIOR AUTHORIZATION

Providers are required to seek prior authorization for certain specified services **before** delivery of the services. In addition to services that are available through the traditional Medicaid Program, expanded services are available to children 20 years of age and under through the Healthy Children and Youth (HCY) Program. Some expanded services also require prior authorization.

The following general guidelines pertain to all prior authorized services.

- A Prior Authorization (PA) Request (yellow form) **must** be completed and mailed to: Verizon, P.O. Box 5700, Jefferson City, MO 65102. Providers should keep a copy of the original PA Request form, as the form is not returned to the provider.

- The provider performing the service **must** submit the PA Request form. Sufficient documentation or information **must** be included with the request to determine the medical necessity of the service.

- The service **must** be ordered by a physician, nurse practitioner, dentist, or other appropriate health care provider.

- Do **not** request prior authorization for services to be provided to an ineligible person. Authorization considers medical necessity only and does not examine eligibility.

- Expanded HCY (EPSDT) services are limited to recipients under the age of 21 and are **not** reimbursed for recipients 21 and over even if prior authorized.

- Prior authorization does **not** guarantee payment if the recipient is or becomes enrolled in managed care and the service is a covered benefit.

- Payment is **not** made for services initiated before the approval date on the PA Request form or after the authorization deadline. For services to continue after the expiration date of an existing PA Request, a new PA Request **must** be completed and mailed.

Whether the prior authorization is approved or denied, a disposition letter will be returned to the provider containing all of the detail information related to the prior authorization request. Any other documentation submitted with the prior authorization request will not be returned with the exception of x-rays and dental molds. All requests for changes to an approved prior authorization should be indicated on the disposition letter and submitted to the same address as the original prior authorization request.

Instructions for completing the PA Request form are found in Section 8 of the Medicaid *Provider's Manual* available on the Internet at www.dss.state.mo.us/dms.

SECTION 6
ADJUSTMENTS

Providers who are paid incorrectly for a claim may use the paper *Individual Adjustment Request* form to request an adjustment. Providers may also submit an adjustment via the internet by using the claim frequency type option 7 for replacement and 8 for void. Adjustments may not be requested when the net difference in payment is less than $4.00, or $.25 for pharmacy, per claim. If the adjustment is due to an insurance payment, or involves Medicare, the $4.00, or $.25, minimum limitation does not apply.

In some instances, more than one change may be necessary on a claim. **All** the changes to the claim must be addressed on the same *Individual Adjustment Request* form. Specify all the changes required, addressing each change separately. Field 15 of the form may be used to provide additional information. More than one claim **cannot** be processed per *Individual Adjustment Request* form. Each adjustment request addresses one particular claim. A separate *Individual Adjustment Request* form must be completed for each claim that requires changes, even if the changes or errors are of a similar nature or are for the same patient.

Providers submitting adjustment requests for changes in procedure codes must provide documentation for these changes. A copy of the original claim and the medical or operative report must be attached, along with any other information pertaining to the claim.

If an adjustment does not appear on a Remittance Advice within 90 days of submission, a copy of the original *Individual Adjustment Request* and attachments should be resubmitted. Photocopies are acceptable. Mark this copy with the word “Tracer”. Submitting another request without indicating it as a “tracer” can further delay processing.

See Section 4 of the Medicaid *Provider Manual* for timely filing requirements for adjustments and claim resubmissions. *Individual Adjustment Requests* form are to be submitted to the address shown on the form.

A sample Individual Adjustment Request is shown on the following page.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
MISSOURI MEDICAID

INDIVIDUAL ADJUSTMENT REQUEST

☐ UNDERPAYMENT ☑ OVERPAYMENT

TO FACILITATE PROCESSING, PLEASE ATTACH THE FOLLOWING:
1. Claim Copy
2. Remittance Advice Copy

FORWARD ORIGINAL TO:
ATTENTION: ADJUSTMENT UNIT
DIVISION OF MEDICAL SERVICES
P O BOX 6500
JEFFERSON CITY MO 65102

PLEASE ENTER THE FOLLOWING DATA FROM YOUR REMITTANCE ADVICE:

3. INTERNAL CONTROL NUMBER 1503225192499	6. RECIPIENT NAME Nelson, Harriett
4. RECIPIENT MEDICAID NUMBER 12345678	7. REMITTANCE ADVICE DATE 08/22/2003

5. PROVIDER LABEL Scott, David 200000000 486 Doctors Lane Medical City, MO 60000	8. R.A. PAGE NUMBER 7

REFER TO PROVIDER MANUAL ADJUSTMENT SECTION FOR INSTRUCTIONS

	SERVICE DATE	INFORMATION ON REMITTANCE ADVICE	CORRECTED INFORMATION
8. QTY/UNITS			
9. NDC/PROCEDURE CODE			
10. SERVICE DATE(S)			
11. BILLED AMOUNT			
12. PAID AMOUNT	08/04/2003	$24.00	$0.00
13. PATIENT SURPLUS			
14. OTHER RESOURCES (TPL) (IDENTIFY SOURCE)			

15. OTHER/REMARKS

Billed Medicaid in error. Please take back payment.

HELPFUL HINTS FOR FILING AN ADJUSTMENT REQUEST FORM

1. **Only one Internal Control Number (ICN) is allowed per adjustment request.**
2. **If you want Medicaid to recoup an entire payment, do *not* enter each line of the claim. Instead, complete the top of the form and line 12 only. Enter the date of service, the amount Medicaid paid and a "0" in the corrected information field.**
3. **When a change to a claim is necessary, such as a service date or quantity, use the ICN of the claim which paid and file an adjustment request. Do *not* send a new claim as it will deny as a duplicate.**
4. **An ICN beginning with a 70 or 75 credits or recoups the original paid claim; an ICN beginning with a 50 or 55 repays the claim with the corrected payment information.**
5. **Use the "Remarks" section of the adjustment request form to explain the reason for the correction.**

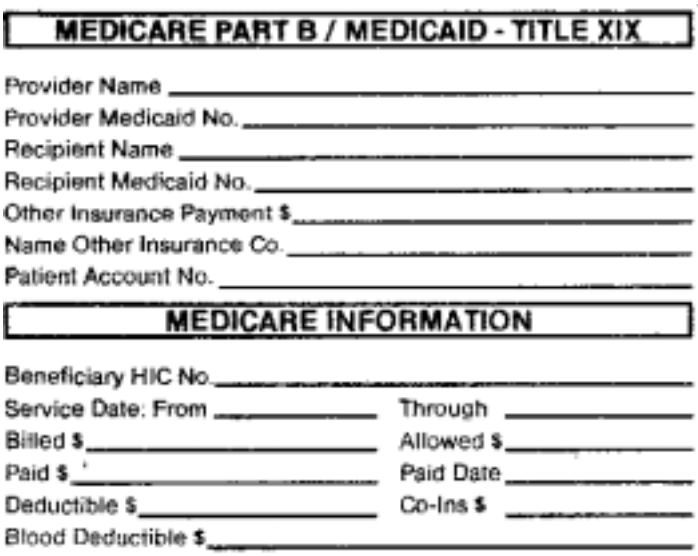
16. PROVIDER'S SIGNATURE	TITLE	DATE
		09/30/2003

MO 886-1019E (4-96) MO 8810

SECTION 7
INSTRUCTIONS FOR COMPLETING THE MEDICARE PART B CROSSOVER STICKER

The Medicare Part B sticker should be legibly printed by hand or electronically. Complete the Medicare Part B/Medicaid-Title XIX sticker as follows and attach it to the Medicare Remittance Advice/Explanation of Medicare Benefits so it does not cover the recipient's identifying information or claim payment information. Completed crossover claims should be mailed to:

Verizon Information Technologies
PO Box 5600
Jefferson City, MO 65102


MEDICARE PART B / MEDICAID - TITLE XIX

Provider Name _____
Provider Medicaid No. _____
Recipient Name _____
Recipient Medicaid No. _____
Other Insurance Payment $ _____
Name Other Insurance Co. _____
Patient Account No. _____

MEDICARE INFORMATION

Beneficiary HIC No. _____
Service Date: From _____ Through _____
Billed $ _____ Allowed $ _____
Paid $ _____ Paid Date _____
Deductible $ _____ Co-Ins $ _____
Blood Deductible $ _____

Field number & name		Instruction for completion
1.	Provider Name	Enter the provider's name as shown on the provider label.
2.	Provider Medicaid Number	Enter the provider's nine-digit Medicaid number.

3.	Recipient Name	Enter the patient's name exactly as shown on the ID card. (last name, first name).
4.	Recipient Medicaid Number	Enter the recipient's eight-digit identification number as shown on the ID card.
5.	Other Insurance Payment	Enter the amount paid by any other insurance.
6.	Name Other Insurance Company	If an insurance amount is shown on line 5, enter name of insurance company. If the insurance plan denied payment, enter the plan name and attach a copy of the insurance denial to the claim.
7.	Patient Account Number	For the provider's own information, a patient account number may be entered here.
8.	Beneficiary HIC Number	Enter the patient's HIC Number as shown on the Medicare card.
9. & 10.	Service Date: From and Through	Enter the date of service. If multiple dates of service are shown on the Medicare RA/EOMB for a single claim, enter the first chronological date of service in "From" field and the last chronological date of service in "Through" field.
11.	Billed	Enter the total Medicare billed amount for the claim. Use the amount shown on the Medicare RA/EOMB.
12.	Allowed	Enter the total Medicare allowed amount for the claim. Use the amount shown on the Medicare RA/EOMB.
13.	Paid	Enter the total amount paid for the claim by Medicare.
14.	Paid Date	Enter the date shown at the top of the Medicare RA/EOMB.
15.*	Deductible	If any deductible was applied on this claim, enter the amount due in this field.

16.*	Co-insurance	Enter the total amount of co-insurance due on this claim.
17.	Blood Deductible	If there is a blood deductible due, enter that amount.

* Do not enter deductible and coinsurance amounts in the same field. They must each be listed in their own field.

MEDICARE BILLING TIPS

BILLING WHEN MEDICARE HAS A DIFFERENT PATIENT NAME THAN MEDICAID

On the paper crossover sticker, show the Medicaid name first with the Medicare name in parenthesis behind it, e.g. Smith, Roberta (Bobbi) or Jones (Masters), Gerald.

CLAIMS NOT CROSSING OVER ELECTRONICALLY

If none of a provider's Medicare claims are crossing over to Medicaid electronically, contact Medicaid to see if the provider has a Medicare number on file and that it is the correct one. Although Medicare advises that a claim was forwarded to Medicaid for processing, this does not guarantee that Medicaid received the claim information or was able to process it. If there is a problem with the claim or the recipient or provider files, the claim will not process. **A provider should wait 60 days from the date a claim was paid by Medicare before filing a crossover claim with Medicaid.** If a claim is submitted sooner, it is possible that the provider will receive a duplicate payment. If this occurs, the provider must submit an Individual Adjustment Request form to have Medicaid take back one of the payments.

TIMELY FILING

Claims initially filed with Medicare within Medicare timely filing requirements and that require separate filing of a crossover claim with Medicaid must meet the timely filing requirements by being submitted by the provider and received by the Medicaid agency within 12 months from the date of service or six months from the date on the provider's Medicare Explanation of Medicare Benefits (EOMB), whichever date is *later*. The counting of the six-month period begins with the date of adjudication of the Medicare payment and ends with the date of receipt.

BILLING FOR ELIGIBLE DAYS

A provider may attempt to bill only for eligible days on the Medicaid Part B claim form. In order for crossover claims to process correctly, a provider must bill all dates of service shown on the Medicare EOMB. The Medicaid claims system will catch those days' claims containing ineligible days and the claim will be prorated for the eligible days only.

ADJUSTMENTS

If Medicare adjusts a claim and Medicaid has paid the original crossover claim, then the original claim payment from Medicaid should be adjusted using an Individual Adjustment Request form with both Medicare EOMBs attached to the form.

SECTION 8
RESOURCE PUBLICATIONS FOR PROVIDERS

CURRENT PROCEDURE TERMINOLOGY (CPT)

Missouri Medicaid uses the latest version of the *Current Procedural Terminology* (CPT). All provider offices should obtain and refer to the CPT book to assure proper coding. Providers can order a CPT book from the American Medical Association.

Order Department
American Medical Association
PO Box 7046
Dover, DE 19903-7046
Telephone Number: 800/621-8335
Fax Orders: 312/464-5600

ICD-9-CM

The *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9) is the publication used for proper diagnostic coding. The diagnosis code is a required field on certain claim forms and the accuracy of the code that describes the patient's condition is important. The publication can be ordered from the following source.

Ingenix Publications
PO Box 27116
Salt Lake City, UT 84127-0116
800/464-3649
Fax Orders: 801/982-4033
www.IngenixOnline.com

HEALTH CARE PROCEDURE CODING SYSTEM (HCPCS)

Medicaid also uses the *Health Care Procedure Coding System (HCPCS), National Level II*. It is a listing of codes and descriptive terminology used for reporting the provision of supplies, materials, injections and certain services and procedures. The publication can be ordered from the following.

Practice Management Information Corporation
4727 Wilshire Blvd. Ste 300
Los Angles, CA 90010
800/633-7467
http://pmiconline.com

SECTION 9
RECIPIENT LIABILITY
State Regulation 13CSR 70-4.030

If an enrolled Medicaid provider does not want to accept Missouri Medicaid as payment but instead wants the patient (recipient) to be responsible for the payment (be a private pay patient), there must be a written agreement between the patient and the provider in which the patient understands and agrees that Medicaid will not be billed for the service(s) and that the patient is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the patient and the provider. **The agreement must be done prior to the service(s) being rendered.** A copy of the agreement must be kept in the patient's medical record.

If there is no evidence of this written agreement, the provider cannot bill the patient and must submit a claim to Medicaid for reimbursement for the covered service(s).

If Medicaid denies payment for a service because all policies, rules and regulations of the Missouri Medicaid program were not followed (e.g., Prior Authorization, Second Surgical Opinion, etc.), the patient is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before Medicaid is billed.

SECTION 10
FORMS

On the following pages are copies of various forms used by the Missouri Medicaid program.

Certain Medicaid programs, services and supplies require the submission of a form before a claim can be processed for payment.

Copies of the forms are available from Medicaid from the following sources.

- Contact the Provider Communications Unit at 800/392-0938 or 573/751-2896.
- Go to the Medicaid website, www.dss.mo.gov/dms, and select and click on the link to the Missouri Medicaid Provider Manuals.
- Use the Verizon order form found at the end of this section.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
MISSOURI MEDICAID INSURANCE RESOURCE REPORT

TPL-4

Submit this form to notify the Medicaid agency of insurance information that you have verified for a Medicaid recipient. Please send the completed form to:

Department of Social Services
Division of Medical Services
Attention: TPL Unit
P.O. Box 6500
Jefferson City, MO 65102-6500

DO **NOT** SEND CLAIMS WITH THIS FORM. YOUR CLAIM WILL NOT BE PROCESSED FOR PAYMENT IF ATTACHED TO THIS FORM.

PROVIDER IDENTIFICATION NUMBER	DATE (MM / DD / YY)
___ ___ ___ ___ ___ ___ ___ ___ ___	
PROVIDER NAME	

CHECK THE APPROPRIATE BOX FOR THE REQUESTED ACTION

☐ ADD NEW RESOURCE OR ☐ CHANGE MEDICAID RESOURCE FILES

RECIPIENT NAME	MEDICAID I.D. NUMBER
	___ ___ ___ ___ ___ ___ ___ ___
INSURANCE COMPANY NAME	
POLICYHOLDER (IF OTHER THAN RECIPIENT)	POLICYHOLDER'S SOCIAL SECURITY NUMBER
POLICY NUMBER	GROUP NAME OR NUMBER

VERIFIED INFORMATION

_____

_____

SOURCE OF VERIFIED INFORMATION: ☐ EMPLOYER ☐ INSURANCE COMPANY

TELEPHONE NUMBER OF CONTACT	DATE CONTACTED (MM / DD / YY)
( )	
NAME OF PERSON COMPLETING THIS FORM	TELEPHONE NUMBER

Do you want confirmation of this add/update?
(If yes, you **must** complete the name and address on back) ☐ YES ☐ NO

ATTACH A COPY OF AN EXPLANATION OF BENEFITS OR INSURANCE LETTER IF AVAILABLE

MO 886-2983 (2-97)

TO BE COMPLETED BY THE PROVIDER

If confirmation of this add/update is requested, please write the name and address of the person the confirmation should be sent to below. The TPL Unit will complete the bottom portion of this form and mail to the address shown.

_____

_____

_____

TO BE COMPLETED BY THE STATE

❑ Verification and correction as requested completed Date: _____

Insurance Begin Date: _____ Insurance End Date: _____

❑ Please resubmit claims

❑ Form not complete enough for verification by state - complete highlighted areas and resubmit

❑ TPL file already reflects the add/update. Our records were updated: _____

❑ Verification confirms Medicaid resource file correct as is - no update performed

❑ Change requested cannot be made. Reason:

_____

_____

_____

❑ Verification shows another current coverage that may be applicable:

_____

_____

_____

❑ Other: _____

_____

_____

_____

MO 886-2983 (2-97)

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
PRIOR AUTHORIZATION REQUEST

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the equipment or prosthesis is received by the recipient. **SEE REVERSE SIDE FOR INSTRUCTIONS.**

I. GENERAL INFORMATION

1.	2. NAME (LAST, FIRST, M.I.)	3. DATE OF BIRTH
4. ADDRESS (STREET, CITY, STATE, ZIP CODE)		5. MEDICAID NUMBER
6. PROGNOSIS	7. DIAGNOSIS CODE	8. DIAGNOSIS DESCRIPTION
9. NAME & ADDRESS OF FACILITY WHERE SERVICES ARE TO BE RENDERED IF OTHER THAN HOME OR OFFICE.		

II. HCY (EPSDT) SERVICE REQUEST (MAY REQUIRE PLAN OF CARE)

10. DATE OF HCY SCREEN	11. SCREENING ☐ FULL ☐ INTERPERIODIC ☐ PARTIAL	12. TYPE OF PARTIAL HCY SCREEN
13. SCREENING PROVIDER NAME	14. PROVIDER NUMBER	15. TELEPHONE NUMBER ( )

III. SERVICE INFORMATION (DO NOT WRITE IN SHADED AREAS) FOR STATE USE ONLY

16. REF. NO.	17. TYPE SERV.	18. PROCEDURE CODE	19. FROM	20. THROUGH	21. DESCRIPTION OF SERVICE/ITEM	22. QTY. OR UNITS	23. AMOUNT TO BE CHARGED	APPR.	DENIED	AMOUNT ALLOWED IF PRICED BY REPORT
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										
(9)										
(10)										
(11)										
(12)										

24. DETAILED EXPLANATION OF MEDICAL NECESSITY FOR SERVICES/EQUIPMENT/PROCEDURE/PROSTHESIS (ATTACH ADDITIONAL PAGES IF NECESSARY)

IV. PROVIDER

25. PROVIDER NAME (AFFIX LABEL HERE)

26. ADDRESS

27. MEDICAID PROVIDER NUMBER

28. SIGNATURE | DATE

V. PRESCRIBING/PERFORMING PRACTITIONER

29. NAME | 30. TELEPHONE ( )

31. ADDRESS

32. DATE DISABILITY BEGAN | 33. PERIOD OF MEDICAL NEED IN MONTHS

I certify that the information given in Sections I and III of this form is true, accurate, and complete.

34. SIGNATURE OF PRESCRIBING PHYSICIAN/PRACTITIONER | DATE

VI. FOR STATE OFFICE USE ONLY

DENIAL REASON(S): REFER TO FIELD 16 ABOVE BY REFERENCE NUMBERS (REF. NO.)

IF APPROVED: services authorized to begin | DATE | REVIEWED BY SIGNATURE ▶

MO 886-0858 (8-01) MO 8809

INSTRUCTIONS FOR COMPLETION

I. GENERAL INFORMATION – To be completed by the provider requesting the prior authorization.

1. Leave Blank
2. Recipients Name – Enter the recipient's name as it appears on the Medicaid ID card. Enter the recipients current address.
3. Date of Birth – Enter the recipient's date of birth.
4. Address – Enter the recipients address, city, state, and zip.
5. Medicaid Number – Enter the recipient's 8-digit Medicaid identification number as shown on the Medicaid identification card or county letter of eligibility.
6. Prognosis – Enter the recipients prognosis.
7. Diagnosis Code – Enter the diagnosis code(s).
8. Diagnosis Description – Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
9. Name and address of the facility where services are to be rendered if service is to be provided other than home or office.

II. HCY SERVICE REQUEST (Plan of care may be required, see your provider manual)

10. Date of HCY Screen – Enter the date the HCY Screen was done.
11. Screening -Check whether the screening performed was FULL, INTERPERIODIC, or PARTIAL.
12. Type of Partial HCY Screen – Enter the type of partial HCY Screen that was performed. (e.g., Vision, Hearing, etc.)
13. Screening Provider Name – Enter the provider's name who performed the screening.
14. Provider Number – Enter the provider's number who performed the screening.
15. Telephone Number – Enter the screening provider's telephone number including the area code.

III. SERVICE INFORMATION

16. Ref. No. = (Reference Number) A unique designator (1-12) identifying each separate line on the request.
17. Type of Service – Enter the appropriate type of service code for each procedure code.
18. Procedure Code – Enter the procedure code(s) for the services being requested.
19. From – Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
20. Through – Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
21. Description of Service/Item – Enter a specific description of the service/item being requested.
22. Quantity or Units – Enter the quantity or units of service/item being requested.
23. Amount to be Charged – Enter the amount to be charged for the service.
24. Detailed Explanation of Medical Necessity of the service, equipment/procedure/prosthesis, etc. Attach additional page(s) as necessary. **Do not use another Prior Authorization Form.**

IV. PROVIDER REQUESTING PRIOR AUTHORIZATION

25. Provider Name – Attach a Medicaid provider label or enter the requested provider's information exactly as it appears on the label.
26. Address – If a Medicaid provider label is not used, enter the complete mailing address in this field.
27. Medicaid Provider Number – If a Medicaid provider label is not used, enter the provider's Medicaid Identification number.
28. Signature/Date -The provider of services should sign the request and indicate the date the form was completed. (Check your provider manual to determine if this field is required.)

V. PRESCRIBING/PERFORMING PRACTITIONER

This section must be completed for services which require a prescription such as Durable Medical Equipment, Physical Therapy, or for services which will be prescribed by a physician/practitioner that require Prior Authorization. Check your provider manual for additional instructions.

29. Name – Enter the name of the prescribing/performing/practitioner.
30. Telephone Number – Enter the prescribing/performing/practitioner telephone number including area code.
31. Address – Enter the address, city, state, and zip code.
32. Date Disability Began – Enter the date the disability began. For example, if a disability originated at birth, enter date of birth.
33. Period of Medical Need in Months – Enter the estimated number of months the recipient will need the equipment/services.
34. Signature of prescribing/performing/practitioner-The prescribing physician/practitioner must sign and indicate the date signed in mm/dd/yy format. **(Signature stamps are not acceptable)**

VI. FOR STATE OFFICE USE ONLY

Approval or denial for each line will be indicated in the box to the right of Section III. Also in this box the consultant will indicate allowed amount if procedure requires manual pricing.

At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 thru 12). The consultant will sign or initial the form.

DS1926

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

APPLICATION FOR PROVIDER DIRECT DEPOSIT

PLEASE TYPE OR PRINT IN BLACK INK ******SEE INSTRUCTIONS ON REVERSE SIDE******

SECTION A **(All providers must complete this section)**

1.TYPE OF DIRECT DEPOSIT ACTION➨ □ New provider/Re-enrollment ✦□ Cancel Direct Deposit ✦□ Change Account/Route number

2.PROVIDER NAME: Complete provider name below as shown on provider labels. **If the Application for Provider Direct Deposit is for a clinic or group,** this form must be accompanied by an Authorization by Clinic Members which **must** contain a list of the provider name(s) and number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic/group, along with the **ORIGINAL** signature of the clinic owner or administrator. All other providers **MUST** complete a **separate** Application for Provider Direct Deposit containing their individual provider number and ***original*** signature. The clinic Application for Provider Direct Deposit will not be processed without the completed Authorization by Clinic Members. **A separate Application for Provider Direct Deposit must be completed for each provider number assigned.**

TYPE OR PRINT PROVIDER NAME HERE ➨

3.PROVIDER NUMBER (enter provider number as shown on provider label, **one provider number per application**)

____ ____ ____ ____ ____ ____ ____ ____ ____

SECTION B **(Complete this section if you wish to enroll in direct deposit OR a change in account/route number(s) is requested.)**
(ATTACH a voided check showing the routing/account numbers, OR if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution completed below. The information completed on this form and the information on the attachment MUST match.

1. ROUTING NUMBER	2. DEPOSITOR ACCOUNT NUMBER
_____	_____

3. TYPE OF ACCOUNT (***must check one***) ➨ □ CHECKING ✦ □ SAVINGS

4. FINANCIAL INSTITUTION NAME	5. BRANCH NUMBER OR NAME (if applicable)
6. FINANCIAL INSTITUTION ADDRESS	7. TELEPHONE NUMBER (include area code)

SECTION C

I wish to participate in Direct Deposit and in doing so:

- ✦ I understand that in endorsing or depositing checks that payment will be from Federal and State funds and that any falsification, or concealment of material fact, may be prosecuted under Federal and State laws.
- ✦ I hereby authorize the State of Missouri to initiate credit entries (deposits) and to initiate, if necessary, debit entries (withdrawals) or adjustments for any **credit entries made in error** to my account designated above.
- ✦ I understand that the State of Missouri may terminate my enrollment in the Direct Deposit program if the State is legally obligated to withhold part or all payments for any reason.
- ✦ I understand that the Division of Medical Services may terminate my enrollment if I no longer meet the eligibility requirements.
- ✦ I understand that this document shall not constitute an amendment or assignment, of any nature whatsoever, of any contract, purchase order or obligation that I may have with an agency of the State of Missouri.

I am authorized to request Direct Deposit on behalf of this clinic/group and in doing so:

- ✦ I acknowledge that each individual in the clinic/group listed on the attached Authorization by Clinic Members has been informed of this request, and also informed that Medicaid funds will be sent to the depositor account specified above.
- ✦ I understand that each individual provider is responsible for all services provided and all billing done under the individual or clinic provider number, regardless to whom the reimbursement is paid. It is each individual provider's responsibility to use the proper billing code and indicate the length of time actually spent providing a service, regardless to whom the reimbursement is paid.

1. ❑ **I HEREBY CANCEL MY DIRECT DEPOSIT AUTHORIZATION** and authorize future payments to be sent to the current payment name and address recorded in the provider enrollment file. ***(Section A number 1 must also be completed)***

2. PROVIDER *ORIGINAL* SIGNATURE (*see requirements on reverse side of this form*)	TYPE OR PRINT NAME SIGNED & TITLE	3.DATE	4.TELEPHONE NUMBER

RETURN ORIGINAL FORM (and original Authorization by Clinic Members, if applicable) ***ALONG WITH A VOIDED CHECK OR LETTER FROM YOUR BANK (see Section B) TO:*** Division of Medical Services, Provider Enrollment Unit, PO Box 6500, Jefferson City MO 65102. Phone 573-751-2617

THIS FORM CANNOT BE FAXED

MO 886-3089 (3-2000)

APPLICATION FOR PROVIDER DIRECT DEPOSIT INSTRUCTIONS

SECTION A ***ALL providers must complete this section***

1.**Type of Direct Deposit Action** -Check appropriate box. **If canceling direct deposit you must also complete Section C, #1.**
2. & 3. **Provider Name and Provider Number** - Enter provider name **and** number **EXACTLY** as shown on your provider label.

SECTION B ***This section must be complete for new applicants or re-enrollments and any changes to your direct deposit information.

ATTACH a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form.** The information completed on this form and the information on the attachment **MUST** match.

1. **Routing Number** - Enter your financial institution's routing number as printed on the bottom left portion of your business checks or deposit tickets (the first 9 digits). See Examples 1 and 2 below.
2. **Depositor Account Number** - Enter depositor account number as printed on the bottom of business checks following the routing number. It may be the first series of digits after the routing number followed by your check number (example 1) or it may be the series of digits which follow your check number (example 2). NOTE: The check number is not included in the depositor account number.

EXAMPLE 1

FINANCIAL INSTITUTION HOMETOWN, USA CHECK NO.4444

PAY TO ORDER OF _____

121456789 8765432109812 4444

↕ Routing No. ↕ Depositor Acct No. ↕ Check No.

EXAMPLE 2

FINANCIAL INSTITUTION HOMETOWN, USA CHECK 4444

PAY TO ORDER OF _____

121456789 4444 8765432109812

↕ Routing No. ↕ Check No. ↕ Depositor Acct No.

*********Credit Unions and Savings and Loan Associations may differ from the above examples. Please VERIFY your DEPOSITOR ACCOUNT NUMBER and ELECTRONIC ROUTING NUMBER with your financial institution.*********

SECTION C

1. **TO CANCEL OR REDESIGNATE:** Complete and submit a new Application for Provider Direct Deposit with the changed information and forward to the Division of Medical Services. **You must check the *CANCEL* box if you wish to *CANCEL* your direct deposit, Section A number 1 must also be completed.** If you elect to cancel direct deposit future payments will be sent to the current payment name and address recorded in the provider enrollment file. Provider direct deposits will continue to be deposited into the designated account at your financial institution until the Division of Medical Services is notified that you wish to ***cancel or redesignate*** your account and/or financial institution.
   DO NOT CLOSE AN OLD ACCOUNT UNTIL THE FIRST PAYMENT IS DEPOSITED INTO YOUR NEW ACCOUNT.
2. **PROVIDER SIGNATURE** - If the provider is enrolled as an individual, he/she must sign the form. Nursing homes, hospitals, independent laboratories and home health agencies must be signed by a person listed on form HCFA-1513 (disclosure of ownership) section III (a). If enrolled as a clinic or business (except those listed above) the form must be signed by the person with fiscal responsibility for the same. **Clinic applications must be accompanied by the Authorization by Clinic Members which must contain** a list of the name(s) and provider number(s) of all Advanced Practice Nurses, CRNA's, Physicians, and Diabetes Self-Management Training providers employed at that clinic location. **The Application for Provider Direct Deposit and the Authorization by Clinic Members MUST be signed by the same person. All other providers must complete** a separate Application for Provider Direct Deposit containing their individual provider number and **original** signature. **A SEPARATE FORM MUST BE COMPLETED FOR EACH PROVIDER NUMBER ASSIGNED.**

OTHER

1. **ATTACH** a voided check showing the routing/account numbers, **OR** if checks are not used attach a letter from your bank, signed by the president or vice president of the bank, verifying the correct routing/account numbers, type of account, and financial institution **to the back of this form.** The information completed on this form and the information on the attachment **MUST** match.
2. Direct deposit will be initiated after a properly completed application form is approved by the Division of Medical Services and the successful processing of a test transaction through the banking system.
3. **This form must be used to change** any financial institution information **or to cancel** your election to participate in direct deposit.
4. The Division of Medical Services will terminate or suspend the direct deposit option for administrative or legal actions including, but not limited to, ownership change, duly executed liens or levies, legal judgements, notice of bankruptcy, administrative sanctions for the purpose of ensuring program compliance, death of a provider and closure or abandonment of an account.
5. If any information completed on this form cannot be verified from the attachments or the form is completed incorrectly, the form(s) will be returned without being processed for direct deposit.

Forms Request

Provider Number: _____ Date: _____
(Or Affix Provider Label Here)

Provider Name: _____

Provider Phone: _____

CLAIM FORMS	Quantity Preprinted	Quantity Blank
A. Pharmacy		
B. Dental		
C. HCFA 1500 (Rev 12/90)		
D. HCFA 1450 (UB-92) Inpatient / Outpatient/ Home Health		
F. Prior Authorization		

CROSSOVER STICKERS

G. Hospital Crossover Sticker (BLACK)	
H. SNF Crossover Sticker (RED)	
I. Part B Crossover Sticker (BLUE)	

If provider labels are needed with blank Claim Forms (A-F), check box. ☐

If you checked box, an equal number of labels will be supplied with Forms A-F. If you DID NOT check box, you WILL NOT receive labels.

If provider labels are needed and you are not ordering Forms A-F, indicate the quantity _____

SPECIAL MAILING INSTRUCTIONS:

Name: _____

Attn: _____

Street Address: _____

_____
(Not P.O. Box)

City: _____

State: _____ Zip: _____

ADDRESS CHANGE / CORRECTION:

Provider Number: _____

Name: _____

Street Address: _____

_____
(Not P.O. Box)

City: _____

State: _____ Zip: _____

Effective Date of Change: _____

ATTACHMENTS	Quantity
J. HCY Medical Screening Tool (All Pages)	
HCY Screening Forms by Age Group	
2. Newborn - 1 month/2 - 3 months	
3. 4 - 5 months/6 - 8 months	
4. 9 - 11 months/12 - 14 months	
5. 15 - 17 months/18 - 23 months	
6. 24 months/3 years	
7. 4 years/5 years	
8. 6 - 7 years/8 - 9 years	
9. 10 - 11 years/12 - 13 years	
*. 14 - 15 years/16 - 17 years	
&. 18 - 19 years/20 years	
K. HCY Lead Risk Assessment Guide	
L. Sterilization Consent	
M. Acknowledge Hysterectomy	
O. Hearing Aid Evaluation	
P. Medical Necessity	
Q. Adjustment Request	
R. Medical Necessity Long Term HPN	
S. Second Surgical Opinion	
T. Medical Necessity - Abortion	
U. Hospice Election Statement	
V. Oxygen - Respiratory Justification	
W. Notification of Termination of Hospice Benefits	
Y. Insurance Resource Report (TPL-4)	
Z. Accident Reporting Form (TPL-2P)	
1. Physician Certification of Terminal Illness	

_____
* Provider Signature: (Must Be Provider's Original Signature)

All requests are delivered to the address on your current provider label unless an address change or correction is requested above. An address change or correction changes your provider billing label. If Special Mailing Instructions are indicated, this and all future requests for forms from Verizon Data Services are delivered to this address until notice of a change is received. A change to Special Mailing Instructions does not change your provider billing label.

The above forms are provided to all participating Missouri Medicaid Providers. They are intended solely for Missouri Medicaid claims filing. Please complete the above information and return it to Verizon Data Services via any paper claims submission P.O. Box. For information regarding electronic claims submission, contact Verizon Data Services at (573) 635-3559.

DS1054 (Rev. 11/00)

NONDISCRIMINATION POLICY STATEMENT

The Missouri Department of Social Services (DSS) is committed to the principles of equal employment opportunity and equal access to services. Accordingly, DSS shall take affirmative action to ensure that employees, applicants for employment, clients, potential clients, and contractors are treated equitably regardless of race, color, national origin, sex, age, disability, religion, or veteran status.

All DSS contracts and vendor agreements shall contain non-discrimination clauses as mandated by the Governor's Executive Order 94-3, Article XIII. Such clauses shall also contain assurances of compliance with Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended/ the Americans with Disabilities Act of 1990 (ADA), as amended; the Age Discrimination Act of 1975, as amended and other pertinent civil rights laws and regulations.

Applicants for, or recipients of services from DSS who believe they have been denied a service or benefit because of race, color, national origin, sex, age, disability or religion may file a complaint by calling the DSS Office for Civil Rights at 1-800-776-8014. Complaints may also be filed by contacting the local office or by writing to:

Missouri Department of Social Services
Office for Civil Rights
P. O. Box 1527
Jefferson City, MO 65102-1527

Or

U.S. Department of Health and Human Services
Office for Civil Rights
601 East 12th Street
Kansas City, MO 64106

Additionally, any person who believes they have been discriminated against in any United States Department of Agriculture related activity (e.g. food stamps, commodity food, etc.) may write to the United States Department of Agriculture at:

USDA Office of Civil Rights
1400 Independence Ave., SW
Mail Stop 9410
Washington, DC 20250

This policy shall be posted in a conspicuous place, accessible to all applicants for services, clients, employees, and applicants for employment, in all divisions, institutions and offices governed by DSS.

Director, Department of Social Services

04/02/03
Date